STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395442	A. BLDG: 00 B. WING:	04/20/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
YORK NORTH SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **025602**	**1770 BARLEY ROAD** **YORK, PA 17408**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification, State Licensure and Civil Rights survey completed on April 20, 2023, it was determined that York North Skilled Nursing and Rehabilitation Center was not in compliance with the following requirements of 42 CFR Part 483 Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0578 SS=E		F 0578		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0578 SS=E	Continued from page 1 483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance	F 0578	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiency (s) herein. To remain in compliance with all federal and state regulations, the facility has taken, and will take, the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been, or will be corrected by the date or dates indicated. The facility is committed to taking all actions necessary to remain in substantial compliance with state and federal regulations. The plan of correction addresses our intention to promote care for our residents which enhances their dignity and is designed to meet their interests and promote the highest practicable level of physical, mental, and psycho-social well-being. 1. R41 is discharged from the facility and has no ill effects from failure to issue advance directive information	Completion Date: **06/06/2023** Status: **APPROVED** Date: **05/03/2023**

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F 0578 SS=E	Continued from page 2 directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by:	F 0578	upon admission. R70 and R130 currently reside in the facility and have been provided with advance directive information. 2. Utilizing the Action Summary report; the Admissions Director/designee will review the last 10 new admissions who currently reside in the facility, the opportunity to form an advance directive. 3. To ensure the deficient practice does not re-occur, the NHA/designee will educate the Admissions Director and Admissions team on the Admissions Advance Directives Policy on or before the date of compliance. 4. Utilizing the Action Summary report, the NHA/designee will audit 5 new admissions per week x4 weeks to ensure advance directive information was provided. Results will be reviewed with QAPI. 5. Facility alleges substantial compliance on June 6, 2023.	

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F 0578 SS=E	Continued from page 3 Based on policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure each resident the right to formulate an advanced directive for three of 30 residents reviewed (Residents 41, 70, and 130). Findings include: An advanced directive is defined as a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor. Review of facility policy, titled "Health Care Decision making", revision date March 1, 2022, read, in part, inquire with the individual's patient representative if the patient is incapacitated at the time of admission as to whether an advanced directive had been completed/executed in accordance with state law. Inform the patient/patient representative of their rights, include the right to	F 0578		

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F 0578 SS=E	Continued from page 4 prepare advance directives, and ask whether they wish to formulate an advance directive. Provide advanced directive information and document that information had been provided to the patient/patient representative. Review of Resident 41's clinical record revealed the Resident was admitted to the facility on March 20, 2023, with diagnosis that include rhabdomyolysis (a breakdown of muscle tissue that releases a protein into the blood that can damage he kidneys), chronic obstructive pulmonary disease (a group of lung disease that block airflow and make it difficult to breathe), and seizure disorder. Review of Resident 41's clinical record revealed a Pennsylvania Orders for Life Sustaining Treatment (POLST- a written medical order that helps give people more control over their own care by specifying the types of medical treatment they want to receive during serious illness) was dated March 21, 2023. Further review of Resident 41's clinical record failed to reveal an advanced directive.	F 0578		

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F 0578 SS=E	Continued from page 5 Review of Resident 70's April 2022 physician orders revealed diagnoses that included heart failure (a lifelong condition in which the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen) and Diabetes Mellitus Type II (A chronic condition that affects the way the body processes blood sugar [glucose], With type 2 diabetes, the body either doesn't produce enough insulin, or it resists insulin). Review of Resident 70's clinical record revealed an admission date of March 24, 2023. Continued review of Resident 70's clinical record revealed no information regarding the facility offering the Resident and/or Representative the opportunity to formulate an advanced directive at admission or after. Review of Resident 130's April 2023 physician orders revealed diagnoses that included hypertension (elevated blood pressure) and anemia	F 0578		

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F 0578 SS=E	Continued from page 6 (a condition in which you lack enough healthy red blood cells to carry adequate oxygen to your body's tissues). Review of Resident 130's clinical record revealed an admission date of February 6, 2023. Continued review of Resident 70's clinical record revealed no information regarding the facility offering the Resident and/or Representative the opportunity to formulate an advanced directive at admission or after. Interview on April 19, 2023, at 11:15 AM, with the Director Of Nursing (DON) revealed that information pertaining to formulating an advanced directive is not reviewed during the admission process. Interview on April 20, 2023, at 10:45 AM, the DON was informed of the concern regarding Resident 41 not being afforded the opportunity during the admission process to formulate an	F 0578		

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F 0578 SS=E	Continued from page 7 advanced directive; no further information was provided. 28 Pa. Code 211.5 (f) Clinical records. 28 Pa. Code 201.18(a)(b)(1)(d)Management 28 Pa. Code 201.29(a) Resident Rights	F 0578		
F 0583 SS=D		F 0583		

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F 0583 SS=D	Continued from page 8 483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in	F 0583	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiency (s) herein. To remain in compliance with all federal and state regulations, the facility has taken, and will take, the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been, or will be corrected by the date or dates indicated. The facility is committed to taking all actions necessary to remain in substantial compliance with state and federal regulations. The plan of correction addresses our intention to promote care for our residents which enhances their dignity and is designed to meet their interests and promote the highest practicable level of physical, mental, and psycho-social well-being. 1. Employee 3 was educated on the Genesis Personal Privacy Policy.	Completion Date: **06/06/2023** Status: **APPROVED** Date: **05/03/2023**

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F 0583 SS=D	Continued from page 9 accordance with State law. This REQUIREMENT is not met as evidenced by:	F 0583	2. Utilizing the current Patient list report; the DON/designee will review all current residents to ensure resident confidentiality is maintained. 3. To ensure the deficient practice does not re-occur, the DON/designee will educate the Licensed Nursing Staff on the Genesis Personal Privacy Policy and F-tag 0583 on or before the date of compliance. 4. The DON/designee will audit 5 med passes per week x4 weeks to ensure resident confidentiality is maintained. Results will be reviewed with QAPI. 5. Facility alleges substantial compliance on June 6, 2023.	

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F 0583 SS=D	Continued from page 10 Based on observation, staff interview, and facility policy review, it was determined that the facility failed to ensure each resident the right to confidentiality of his or her medical record for one of seven resident halls reviewed (200 Hall). Findings Include: Review of the facility's policy, titled "Privacy Rights:Patient" , revised December 5, 2019, revealed "The patient has a right to personal privacy and confidentiality of his/her personal and medical records." The policy continues "Personal privacy includes...medical treatment..." An observation in the 200 Hall, on April 17, 2023, at 12:34 PM, revealed a medication cart unattended by staff and to display resident medical record information on the computer screen. An immediate observation and interview with the assigned Employee 3 (Licensed Practical Nurse), found to be standing at the nurse's station, behind	F 0583		

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F 0583 SS=D	Continued from page 11 the desk area, revealed she stepped away "to get my pen." The observation also revealed Employee 3 in conversation with other staff members. An interview with the Director of Nursing on April 18, 2023, at 11:44 AM, revealed an agreement the medication cart should not have been unattended and resident medical record information should not be displayed. 28 Pa. Code 211.5 (b) Clinical records	F 0583		
F 0641 SS=D		F 0641		

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F 0641 SS=D	Continued from page 12 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiency (s) herein. To remain in compliance with all federal and state regulations, the facility has taken, and will take, the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been, or will be corrected by the date or dates indicated. The facility is committed to taking all actions necessary to remain in substantial compliance with state and federal regulations. The plan of correction addresses our intention to promote care for our residents which enhances their dignity and is designed to meet their interests and promote the highest practicable level of physical, mental, and psycho-social well-being. 1. R139 MDS from January 28, 2023 will be corrected.	Completion Date: **06/06/2023** Status: **APPROVED** Date: **05/03/2023**

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F 0641 SS=D	Continued from page 13	F 0641	2. The RNAC/designee will review the last 10 discharged assessments to ensure accuracy. 3. To prevent the deficient practice from recurrence the NHA/designee will educate the RNACs on F-tag 641 and coding the accurate discharge status on or before the date of compliance. 4. The RNAC/designee will audit 5 discharge assessments per week x 4 weeks to ensure accurate assessments. Results will be reviewed with QAPI. 5. Facility alleges substantial compliance on June 6, 2023.	

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F 0641 SS=D	Continued from page 14 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for one of 30 residents reviewed (Resident 139). Findings Include: Review of Resident 139's clinical record revealed diagnoses that included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe) and gastro esophageal reflux disease (a digestive disease in which stomach acid or bile irritates the food pipe lining). Review of Resident 139's MDS (Minimum Data Set is part of the federally mandated process for clinical assessment of all Medicare and Medicaid certified nursing homes) dated January 28, 2023, revealed that Section A2100 Discharge Status was marked "03. Acute hospital", signifying that Resident 139 had been discharged to an acute care hospital.	F 0641		

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F 0641 SS=D	Continued from page 15 Review of a nursing progress note dated January 28, 2023, at 1:02 PM, revealed that Resident 139 was discharged home with her husband. Interview with the Director of Nursing on April 20, 2023, at 8:32 AM, revealed that the MDS was marked in error and that it will be corrected. 28 Pa. Code 211.5(f) Clinical records 28 Pa Code 211.12 (d)(3)(5) Nursing Services	F 0641		
F 0684 SS=E		F 0684		

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F 0684 SS=E	Continued from page 16 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiency (s) herein. To remain in compliance with all federal and state regulations, the facility has taken, and will take, the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been, or will be corrected by the date or dates indicated. The facility is committed to taking all actions necessary to remain in substantial compliance with state and federal regulations. The plan of correction addresses our intention to promote care for our residents which enhances their dignity and is designed to meet their interests and promote the highest practicable level of physical, mental, and psycho-social well-being. 1. R109 has a physician order and is care planned for the right palm protector.	Completion Date: **06/06/2023** Status: **APPROVED** Date: **05/03/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395442	A. BLDG: __00_____ B. WING: _____	04/20/2023

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F 0684 SS=E	Continued from page 17	F 0684	2. Current residents that require a splint have been reviewed to ensure the plan of care and physician order is accurately reflective of assistive devices. 3. To prevent the deficient practice from recurrence the DON/designee will educate the Licensed Nursing Staff on ensuring MD orders are obtained and care plan is updated on or before the date of compliance. 4. The DON/designee will audit 5 residents that require a splint per week x 4 weeks to ensure compliance. Results will be reviewed with QAPI. 5. Facility alleges substantial compliance on June 6, 2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0684 SS=E	Continued from page 18 Based on review of the clinical record, observations, and staff interview, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for one of 30 residents reviewed (Resident 109). Findings include: Review of Resident 109's clinical record documented diagnoses that included cerebral vascular accident (CVA- stroke damage to the brain from interruption of its blood supply) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following CVA on the right, dominant side. Observation of Resident 109 on April 17th, 2023, at 11:47 AM; April 18th, 2023, at 12:30 PM; and April 19th, 2023, at 10:30 AM revealed Resident 109 was wearing a right palm protector.	F 0684		

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F 0684 SS=E	Continued from page 19 Review of Resident 109's February 2023 and April 2023 medication and treatment administration records (a record of medications and treatments that were administered) failed to document use of a palm protector and/or skin evaluations of the right hand. Review of tasks documentation revealed a restorative program for ambulation; however, there wasn't documentation for use of the palm protector/splinting program. Review of Resident 109's care plan read, in part, activities of daily living self-care deficit due to CVA, with an initiated date of February 11, 2022. Interventions included a right palm protector may remove for hygiene, with an initiated date of February 18, 2022; ambulate up to 50 feet with rolling walker, gait belt, and one person assist, with an initiated date of December 29, 2022; and active range of motion of upper and lower extremities 10 repetitions each during activities of daily living twice daily, with an initiated date of March 2, 2022.	F 0684		

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F 0684 SS=E	Continued from page 20 Review of Resident 109's kardex (a quick reference of a resident's care needs) read, in part, restorative active range of motion of upper and lower extremities (10 repetitions each) during activities of daily living twice daily; restorative ambulation up to 50 feet with a rolling walker, gait belt, and one person assist; and right hand palm protector, may remove for hygiene. Review of Resident 109's Restorative Nursing Status Assessment dated February 14, 2023, documented range of motion and ambulation as restorative care needs, and no documentation of splint or brace assistance. Interview on April 20, 2023, at 10:30 AM, the Director of Nursing (DON) was informed of the concerns that Resident 109 failed to have a physician order for the palm protector, or a system in place to monitor for application of the palm protector, monitoring for skin integrity, and the restorative assessment not incorporating the use of	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0684 SS=E	Continued from page 21 the palm protector. DON stated that therapy would assess the Resident for use of the palm protector and provide nursing guidance; an order would be obtained and monitoring would be initiated for nursing to complete. Interview of April 20, 2023, at 11:51 AM, with the DON revealed that, as of March 2, 2022, Resident 109 was care planned for the use of the palm protector, and that there should've been a physician order for use of the palm protector and monitoring for skin integrity. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0684		
F 0686 SS=D		F 0686		

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F 0686 SS=D	Continued from page 22 483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 0686	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiency (s) herein. To remain in compliance with all federal and state regulations, the facility has taken, and will take, the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been, or will be corrected by the date or dates indicated. The facility is committed to taking all actions necessary to remain in substantial compliance with state and federal regulations. The plan of correction addresses our intention to promote care for our residents which enhances their dignity and is designed to meet their interests and promote the highest practicable level of physical, mental, and psycho-social well-being. 1. R106 resides in the facility and has no ill effects from wound treatment. Employee 4 was educated on the	Completion Date: 06/06/2023 Status: APPROVED Date: 05/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0686 SS=D	Continued from page 23	F 0686	wound treatment process. 2. The DON/designee will complete a record review of 10 residents who require wound treatments to ensure compliance to facility policy to promote healing and prevent infection. 3. To prevent the deficient practice from recurrence the DON/designee will educate the Licensed Nursing Staff on the wound treatment process on or before the date of compliance. 4. The DON/designee will audit/observe 5 resident wound treatments per week x 4 weeks to ensure compliance. Results will be reviewed with QAPI. 5. Facility alleges substantial compliance on June 6, 2023.	

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F 0686 SS=D	Continued from page 24 Based on clinical record review, observation, staff interview, and facility policy review, it was determined that the facility failed to ensure necessary treatment and services to promote healing and prevent infection were provided to one of one residents observed for wound dressing changes (Resident 106). Findings include: Review of facility policy, titled "NSG241 Treatments," last revised June 1, 2021, revealed it was the facility's policy that, "A licensed nurse or medical technician, per state regulations, will perform ordered treatments. Accepted standards of practice will be followed." And that the Policy's purpose was, "To provide a safe and effective administration of treatments." Review of Resident 106's clinical record on April 18, 2023, at approximately 9:30 AM, revealed diagnoses including dementia (irreversible, progressive degenerative disease of the brain that	F 0686		

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F 0686 SS=D	Continued from page 25 results in decreased contact with reality and decreased ability to perform activities of daily living) and a stage 4 pressure ulcer (injury of the skin that extends to the underlying bone and/or connective tissue, which is the result of pressure over a bony area). During wound treatment observation on April 19, 2023, at approximately 1:00 PM, Employee 4 was observed preparing Resident 106's treatment supplies at the treatment cart located in the hallway. After Employee 4 had all the treatment supplies prepared, Employee 4 was observed donning gloves, after which, Employee 4 picked up the supplies and started to walk towards Resident 106's room. While walking to Resident 106's room Employee 4 was observed dropping an extra pair of gloves on the floor. Employee 4 then used her gloved hands to pick up the extra pair of gloves off the floor and discarded them into a trash can. Employee 4 then proceeded to enter Resident 106's room.	F 0686		

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F 0686 SS=D	Continued from page 26 Once at Resident 106's bedside, Employee 4 removed Resident 106's prior stage 4 pressure ulcer wound dressing, and cleansed the wound without performing hand hygiene nor changing the gloves that were donned in the hallway. After removing the prior stage 4 pressure ulcer wound dressing and cleansing the wound, Employee 4 doffed and donned a new pair of gloves; however, Employee 4 did not perform hand hygiene between glove changes. Employee 4 was then observed preparing to apply ordered cream to the peri-wound (skin directly around the stage 4 pressure ulcer) area. Just prior to dispensing the ordered barrier cream to her right index finger, Employee 4 was observed adjusting her glasses, located on her face, with her right hand. Employee then dispensed the ordered barrier cream to the right index finger and proceeded to apply the cream to the peri-wound area. After touching her glasses and applying the peri-wound barrier cream and without changing gloves or performing hand hygiene, Employee 4 was	F 0686		

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F 0686 SS=D	Continued from page 27 observed handling and cutting a collagen wound dressing with her right gloved hand. Employee 4 subsequently inserted the collagen wound dressing into Resident 106's stage 4 pressure ulcer. After applying a foam dressing to the wound, Employee 4 removed her gloves and confirmed that she was finished with the dressing change. During a staff interview on April 20, 2023, at approximately 11:30 AM, Director of Nursing revealed it was the facility's expectation that staff perform hand hygiene and don new gloves prior to accessing a resident's wound and between removal of a dressing, cleansing a wound, and prior to applying a new dressing. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0686		
F 0689 SS=D		F 0689		

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F 0689 SS=D	Continued from page 28 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiency (s) herein. To remain in compliance with all federal and state regulations, the facility has taken, and will take, the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been, or will be corrected by the date or dates indicated. The facility is committed to taking all actions necessary to remain in substantial compliance with state and federal regulations. The plan of correction addresses our intention to promote care for our residents which enhances their dignity and is designed to meet their interests and promote the highest practicable level of physical, mental, and psycho-social well-being. 1. Employee 3 was educated on the General Dose Preparation and Medication Administration policy.	Completion Date: **06/06/2023** Status: **APPROVED** Date: **05/08/2023**

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F 0689 SS=D	Continued from page 29	F 0689	2. The DON/designee will complete a direct observation of med passes to ensure medications are not left unattended and the med cart is secured. 3. To prevent the deficient practice from re-occurrence the DON/designee will educate the Licensed Nursing staff on the General Dose Preparation and Medication Administration policy on or before the date of compliance. 4. The DON/designee will audit 5 resident's med passes through direct observation per week x 4 weeks to ensure compliance. Results will be reviewed with QAPI. 5. Facility alleges substantial compliance on June 6, 2023.	

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F 0689 SS=D	Continued from page 30 Based on observation, facility policy review, and staff interview, it was determined that the facility failed to ensure a resident environment remains free of accident hazards for one of seven resident halls reviewed (200 Hall). Findings Include: Review of the facility's policy, titled "General Dose Preparation and Medication Administration", recently revised January 1, 2022, reads, in part, "Facility staff shall not leave medications or chemicals unattended." An observation on April 17, 2023, at 12:34 PM, revealed an unattended medication cart in the 200 Hall with several insulin pens and one cup containing medication. An immediate observation and interview with the assigned Employee 3 (Licensed Practical Nurse), found to be standing at the nurse's station, behind the desk area, revealed she stepped away "to get	F 0689		

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F 0689 SS=D	Continued from page 31 my pen." The observation also revealed Employee 3 in conversation with other staff members. An interview with the Director of Nursing, on April 18, 2023, at 11:44 AM, revealed an agreement the medication cart, with medications present, should not have been unattended by Employee 3. 211.12 (d) (1) (2) Nursing services	F 0689		
F 0730 SS=E		F 0730		

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F 0730 SS=E	Continued from page 32 483.35(d)(7) Nurse Aide Peform Review-12 hr/yr In-Service §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:	F 0730	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiency (s) herein. To remain in compliance with all federal and state regulations, the facility has taken, and will take, the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been, or will be corrected by the date or dates indicated. The facility is committed to taking all actions necessary to remain in substantial compliance with state and federal regulations. The plan of correction addresses our intention to promote care for our residents which enhances their dignity and is designed to meet their interests and promote the highest practicable level of physical, mental, and psycho-social well-being. 1. Employees 5, 6, and 7 were given updated annual performance	Completion Date: **06/06/2023** Status: **APPROVED** Date: **05/03/2023**

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	395442	A. BLDG: __00_____ B. WING: _____	04/20/2023

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YORK NORTH SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **025602**	**1770 BARLEY ROAD YORK, PA 17408**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0730 SS=E	Continued from page 33	F 0730	reviews. 2. The HRD/designee will complete a review of current employee files to ensure annual performance reviews were completed and up to date. 3. To prevent the deficient practice from re-occurrence the NHA/designee will educate the HRD and Payroll on F-tag 0730 on or before the date of compliance. 4. The HRD/designee will audit 5 employee files per week x 4 weeks to ensure compliance. Results will be reviewed with QAPI. 5. Facility alleges substantial compliance on June 6, 2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395442	A. BLDG: 00 B. WING:	04/20/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
YORK NORTH SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 025602	1770 BARLEY ROAD YORK, PA 17408

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F 0730 SS=E	Continued from page 34 Based on document review and staff interview, it was determined that the facility failed to ensure an annual performance review is completed for each nurse aide for three of five nurse aide performance reviews documented (Employees 5, 6, and 7). Findings Include: Review of Employee 5's most recent performance review revealed a date of January 13, 2022. Review of Employees 6's most recent performance review revealed a date of October 14, 2021. Review of Employee 7's most recent performance review revealed a date of October 14, 2021. An interview with the Director of Nursing, on April 19, 2023, at 2:07 PM, confirmed the annual performance reviews for the aforementioned employees were not completed on an annual basis. 28 Pa. Code 201.14 (a) Responsibility of licensee	F 0730		

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STATE LICENSE NUMBER: **025602**	

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F 0803 SS=E		F 0803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395442	A. BLDG: 00 B. WING:	04/20/2023

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F 0803 SS=E	Continued from page 36 483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by:	F 0803	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiency (s) herein. To remain in compliance with all federal and state regulations, the facility has taken, and will take, the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been, or will be corrected by the date or dates indicated. The facility is committed to taking all actions necessary to remain in substantial compliance with state and federal regulations. The plan of correction addresses our intention to promote care for our residents which enhances their dignity and is designed to meet their interests and promote the highest practicable level of physical, mental, and psycho-social well-being. 1. R105 has no ill effects from failure to provide garlic bread.	Completion Date: **06/06/2023** Status: **APPROVED** Date: **05/03/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0803 SS=E	Continued from page 37 Based on the investigation, interview, [illegible] facility [illegible] 1.8, [illegible]	F 0803	2. The Dietician/designee will review the menus to ensure tray accuracy. 3. To prevent the deficient practice from re-occurrence the Dietitian/designee will educate the Dietary staff on Menu and tray accuracy on or before the date of compliance. 4. The Dietitian/designee will audit 5 trays per week x 4 weeks to ensure compliance. Results will be reviewed with QAPI. 5. Facility alleges substantial compliance on June 6, 2023.	
F 0880 SS=D		F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0880 SS=D	Continued from page 38 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiency (s) herein. To remain in compliance with all federal and state regulations, the facility has taken, and will take, the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been, or will be corrected by the date or dates indicated. The facility is committed to taking all actions necessary to remain in substantial compliance with state and federal regulations. The plan of correction addresses our intention to promote care for our residents which enhances their dignity and is designed to meet their interests and promote the highest practicable level of physical, mental, and psycho-social well-being. 1. Employee 4 was educated on the Infection Control hand hygiene practices.	Completion Date: **06/06/2023** Status: **APPROVED** Date: **05/08/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0880 SS=D	Continued from page 39 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	2. The DON/designee will complete a record review of 10 residents who require wound treatments to ensure hand hygiene practices are being followed. 3. To prevent the deficient practice from recurrence the DON/designee will educate the Licensed Nursing Staff on the infection control hand hygiene practices on or before the date of compliance. 4. The DON/designee will audit 5 resident wound treatments through direct observation per week x 4 weeks to ensure compliance. Results will be reviewed with QAPI 5. Facility alleges substantial compliance on June 6, 2023.	

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F 0880 SS=D	Continued from page 40	F 0880		

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F 0880 SS=D	Continued from page 41 Based on observation and staff interview, it was determined that the facility failed to maintain proper infection control hand hygiene practices to help prevent the development of and transmission of communicable disease and infections for one of one treatment carts observed (600 Hall treatment cart). Findings include: After observing Employee 4 perform a wound dressing change on April 19, 2023, at approximately 1:00 PM, Employee 4 was observed exiting the resident room with a plastic bag containing treatment supplies, a plastic bag containing soiled used dressing material, and a small cloth towel. Employee 4 was observed holding the bag of soiled dressing material and treatment supplies in her left hand and the used cloth towel in her right hand. Employee 4 was observed entering the unit's soiled utility room. Employee 4 discarded the small cloth towel in a laundry bin and exited the soiled utility	F 0880		

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F 0880 SS=D	Continued from page 42 room. Employee 4 still possessed the bag of soiled dressing material and bag of treatment supplies in her left hand as she was observed exiting the soiled utility room. Employee 4 was then observed accessing the bag with treatment supplies, removing an open collagen dressing packet, and placing the open collagen dressing packet in the bottom drawer. Employee 4 was then observed placing the bag of the remaining treatment supplies in a separate drawer. Employee then accessed the bottom drawer to remove the open collagen dressing packet and placed it inside the bag with treatment supplies in the separate drawer. Employee 4 was observed accessing the treatment cart and handling the treatment supplies after entering and exiting the soiled utility room, without performing hand hygiene, and also while holding a bag of soiled treatment supplies. During a staff interview on April 20, 2023, at approximately 11:00 AM, Director of Nursing revealed it was the facility's expectation that	F 0880		

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F 0880 SS=D	Continued from page 43 Employee 4 should have performed hand hygiene after accessing the soiled utility room and then accessing the treatment cart. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0880		
F 0947 SS=E		F 0947		

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F 0947 SS=E	Continued from page 44 483.95(g)(1)-(4) Required In-Service Training for Nurse Aides §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by:	F 0947	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiency (s) herein. To remain in compliance with all federal and state regulations, the facility has taken, and will take, the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been, or will be corrected by the date or dates indicated. The facility is committed to taking all actions necessary to remain in substantial compliance with state and federal regulations. The plan of correction addresses our intention to promote care for our residents which enhances their dignity and is designed to meet their interests and promote the highest practicable level of physical, mental, and psycho-social well-being. 1. Employees 8 and 9 were educated on completing annual 12 hour nurse aide training requirements.	Completion Date: **06/06/2023** Status: **APPROVED** Date: **05/03/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0947 SS=E	Continued from page 45	F 0947	2. The HRD/designee will complete a review of current CNA training transcripts to ensure training is on track for the year. 3. To prevent the deficient practice from recurrence the NHA/designee will educate the HRD on F-tag 0947 on or before the date of compliance. 4. The HRD/designee will audit 5 employee transcripts per week x 4 weeks to ensure compliance. Results will be reviewed with QAPI. 5. Facility alleges substantial compliance on June 6, 2023.	

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F 0947 SS=E	Continued from page 46 Based on document review and staff interview, it was determined that the facility failed to ensure the required in-service training for nurse aides is no less than 12 hours per year for two of five nurse aide training hours reviewed (Employees 8 and 9). Findings Include: Review of the facility's documented annual nurse aide training hours for Employee 8 and Employee 9 revealed the total number to be less than the required 12 hours. An interview with the Director of Nursing, on April 20, 2023, at 8:54 AM, confirmed Employees 8 and 9 did not complete the required 12 hours of annual training. 28 Pa. Code 201.20 (c) Staff development	F 0947		

Certified End Page

YORK NORTH SKILLED NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 025602

SURVEY EXIT DATE: 04/20/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY